

**STATE OF LOUISIANA
CERTIFICATE OF IMMUNIZATION**

EXPIRATION DATE month_____ day_____ year_____

(Enter the date that the next immunization is due above)

This record is invalid without proper expiration date

Child's Name	Date of Birth		Parent or Guardian		
VACCINE	MONTH, DAY AND YEAR EACH DOSE WAS GIVEN				
	first	second	third	fourth	fifth
DTP / DtaP / DT					
OPV / IPV					
HIB					
MMR					
HBV					
Varicella					

I certify that this child has received the above noted immunizations and is in compliance with rules set forth by the State of Louisiana, Department of Health and Hospitals, Office of Public Health until the expiration date above.

Authorized Signature

Date

Clinic of Issue

IMM-6 (7-95)

INSTRUCTIONS

Falsification of this record could result in imprisonment for not more than five years or by a fine of not more than five thousand dollars, or both, pursuant to R.S. 14:132 or R.S. 14:133.

Expiration Date: The month, day and year the child's next immunization(s) is/are due according to the Louisiana Office of Public health, immunization Program Schedule. This record is invalid without an expiration date

Child's Name: The child's last name, first name, and middle name or initial.

Date of Birth: Month, day and year

Parent or Guardian: The parent or guardian's last and first name.

Vaccine: The following vaccine abbreviations are used; DTP = Diphtheris-Tetanus-Pertussis Vaccine; DtaP = Diphtherisa-Tetanus-Acellular Pertussis Vaccine; DT = Pediatric Diptheria-tetanus Vaccine; OPV = Oral Polio Vaccine; IPV = Inactivated Polio Vaccine; HIB = Haemophilus Influenza Type B Vaccine; MMR = Measles-Mumps-Rubella Vaccine; HBV = Hepatitis B Vaccine; DTP-HIB = Diptheria-Tetanus-Pertussis-Haemophilus Influenza Type B Vaccine.

If DTP-HIB vaccine is used administration dats should be recorded as both DTP and HIB.

Hepatitis B vaccination will be required by state law for children in child care effective Fall enrollment 1998.

Immunization Doses: The month, day and year of each dose.

Authorized Signature: The signature of a representative of a public or private medical proctice or clinic.

Date: The date the certificate is issued.

Clinic of issue: The clinic or practice issuing the certificate.